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	MHL0411172	A. BUILDING: _____ B. WING _____	R 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUCCESSFUL VISIONS, LLC	1906 GREENSTONE PLACE HIGH POINT, NC 27265

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 12/21/22. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to conduct fire and disaster drills on each shift at least quarterly. The findings are: Interview on 12/21/22 with staff #2 revealed shifts	V 114	Staff have been retrained on completion of fire and disaster drills. The updated log have been updated and in log book. Director and Program Manager will ensure that the fire and disaster will be completed on every shift (1st, 2nd, and 3rd) quarterly. DHSR - Mental Health JAN 30 2023 Lic. & Cert. Section	12/28/2022

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V 114	Continued From page 1 consisted of 1st (8:00am - 4:00pm), 2nd (4:00pm - 12:00am) and 3rd (12:00am - 8:00am). Review on 12/21/22 of the facility's fire and disaster drill records revealed: -No documented fire drills on 3rd shift for the quarters of January - March 2022, April - June 2022 and July - September 2022; -No documented disaster drills for the quarters of January - March 2022, April - June 2022 and July - September 2022. Interview on 12/21/22 with client #2 revealed: -Admitted 2/23/22; -Never participated in a fire or disaster drill while at the facility. Interview on 12/21/22 with the Executive Director revealed: -Aware that fire and disaster drills were required to be conducted on each shift at least quarterly; -Was not aware that the fire and disaster drills were not being conducted and documented as required; -"I want everything on a system (electronic);" -If everything were electronic, it would be easier to monitor and verify that drills were completed as required. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written	V 118	MAR will be reviewed daily during shift change. During shift change all staff with review MAR to ensure MAR's and medications have been documented and completed. QP and Program Manager will review MAR daily.	12/28/2022

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V 118	Continued From page 2 order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to keep the MAR current for one of three audited clients. (#3). The findings are: Review on 12/21/22 of client #3's record revealed: -Admission date of 2/27/22;	V 118	Type text here	

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V 118	Continued From page 3 -17 years old; -Diagnoses of Disruptive Mood Dysregulation Disorder and Intermittent Explosive Disorder; -Orders dated 6/2/22 for Clindamycin Phosphate 1 %, apply to acne twice a day (BID) and Saline .65 % Nose Spray, use 2 sprays in each nostril BID for allergies; -Orders dated 8/17/22 for Asenapine 5 milligrams (mg), dissolve 1 tablet under tongue BID for aggression, Levothyroxine 25 micrograms, 1 tablet by mouth (po) every morning before breakfast, Oxcarbazepine 600 mg, 1 tablet po BID, Lithium Carbonate extended release 450 mg to stabilize mood, 1 tablet po BID, and Prazosin 2 mg, 1 capsule po at bedtime (QHS) for nightmares. Review on 12/21/22 of December 2022 MAR for client #3 revealed: -No documentation that Saline was administered in the am on the 3rd; -No documentation that Clindamycin Phosphate was administered in the am on the 5th; -No documentation that any medications were administered in the am on the 15th - 19th; -No documentation that any medications were administered in the pm on the 16th - 18th. Interview on 12/21/22 with the Executive Director revealed: -Client #3 had not been out of the facility during medication administration time in the month of December 2022; -Not aware that medications were not being documented as being administered; -Sure that medications had been administered as ordered; -Staff had been retrained in medication administration after the annual survey was completed in 2021.	V 118		

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V 118	Continued From page 4 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this	V 296	The Director and Program Manager will ensure that all treatment plans reflect that client within the facility has the ability to be transported by one staff, based on diagnosis and behavior. Director and Program Manager will insure that two staff are in the home at all times. Staff completed an in service on rules. On staff is not allowed to leave one staff in the home alone with 1-4 clients.	12/28/2022

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V 296	Continued From page 5 Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to ensure the minimum number of direct care staff required and to ensure supervision of children or adolescents when they are away from the facility in accordance with individual strengths and needs as specified in the treatment plan. The findings are: Review on 12/21/22 of client #1's record revealed: -Admission date of 7/1/22; -14 years old; -Diagnoses included Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder (ADHD). Interview on 12/21/22 with client #1 revealed there were, "mostly 2" staff working at the facility when clients were present. Review on 12/21/22 of client #2's record revealed:	V 296		

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V 296	Continued From page 6 -Admission date of 2/23/22; -14 years old; -Diagnoses included Disruptive Mood Dysregulation Disorder, Post Traumatic Stress Disorder, Conduct Disorder, ADHD and a history of child physical abuse. Review on 12/21/22 of client #3's record revealed: -Admission date of 2/27/22; -17 years old; -Diagnoses included Disruptive Mood Dysregulation Disorder and Intermittent Explosive Disorder. Interview on 12/21/22 with client #3 revealed there was "rarely" only 1 staff working at the facility when clients were present. Observations on 12/21/22 from 12:05pm - 12:14pm revealed: -Staff #1 and clients #1, #2 and #3 were at the facility at 12:05pm; -Staff #2 arrived at the facility at 12:14pm. Interview on 12/21/22 with staff #1 revealed, "She (staff #2) went 5 minutes up the road to get lunch." Interview on 12/21/22 with staff #2 revealed: -Left the facility to go to a local grocery store for bread and milk; -Aware that there were required to be 2 staff in the facility when clients were present; -Clients were regularly transported by 1 staff to appointments; -Not aware that client #2 was not allowed to be transported by 1 staff. Interview on 12/21/22 with the Executive Director	V 296		

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V 296	Continued From page 7 revealed: -Not aware that staff #2 had left the facility leaving staff #1 and 3 clients present; -"They know I'm tied up at the other home (facility) so they try to take care of things here for me;" -Client #2 was sometimes transported with 1 staff; -Thought there was a goal in client #2's treatment plan regarding him being transported by 1 staff. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 296		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of	V 536		

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V 536	Continued From page 8 behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years.	V 536		

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V 536	Continued From page 9 (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.	V 536		

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V 536	Continued From page 10 (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 4 audited staff (Qualified Professional (QP)) demonstrated competency prior to providing services by completing training on alternatives to restrictive interventions. The	V 536		

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V 536	Continued From page 11 findings are: Review on 12/21/22 of the QP's personnel file revealed: -Hire date of 7/8/18; -No documentation of approved training on alternatives to restrictive interventions. Interview on 12/21/22 with the Executive Director revealed: -Not aware that the QP was required to complete training on alternatives to restrictive interventions because he was qualified to be a licensed professional; -Not aware that she was cited during the previous annual survey in 2021 for the QP not having completed training on alternatives to restrictive interventions. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 536	NCI trainings have been completed and file have been updated with NCI trainings. This will be monitored by the ED and LP who supervises the QP.	1/19/2023
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including	V 537	NCI trainings have been completed and file have been updated with NCI trainings. This will be monitored by the ED and LP who supervises the QP.	1/19/2023

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V 537	Continued From page 12 service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and	V 537		

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V 537	Continued From page 13 psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant	V 537		

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SUCCESSFUL VISIONS, LLC	1906 GREENSTONE PLACE HIGH POINT, NC 27265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 537	Continued From page 14 to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 537	Continued From page 15 times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 4 audited staff (Qualified Professional (QP)) completed training in seclusion, physical restraint and isolation time out prior to providing services. The findings are: Review on 12/21/22 of the QP's personnel file revealed: -Hire date of 7/8/18; -No documentation of approved training in seclusion, physical restraint and isolation time out. Interview on 12/21/22 with the Executive Director revealed: -Not aware that the QP was required to complete training in seclusion, physical restraint and isolation time out because he was qualified to be a licensed professional; -Not aware that she was cited during the previous annual survey in 2021 for the QP not having completed training in seclusion, physical restraint and isolation time out. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 744	Continued From page 16	V 744		
V 744	27G .0304(b) Safety 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. This Rule is not met as evidenced by: Based on observation and interview, the staff failed to ensure the facility was designed, constructed and equipped in a manner that ensured the physical safety of clients, staff and visitors. The findings are: Observation on 12/21/22, at 12:05pm, of the inside of the facility revealed a space heater operating in the office/lounge area. Interview on 12/21/22 with the Executive Director revealed: -Aware that space heaters were not allowed to be utilized in the facility; -Staff had brought space heaters into the facility without her knowledge; -Was going to remove the space heaters from the facility before she left. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 744	Space heater was removed from the facility on 12/21/2022.Staff was advised that space heaters were not allowed in the home for the safety and well being of the clients we serve.	12/21/2022